THE USE OF AN EVIDENCE BASED, BIO/PSYCHO/SOCIAL MODEL

IN SOCIAL WORK MENTAL HEALTH PRACTICE

Mary Ann Test November 14, 2001

KEY VALUES & ASSUMPTIONS IN TEACHING ABOUT MENTAL ILLNESS

1) RESPECT FOR PEOPLE WITH MENTAL ILLNESS & THEIR FAMILIES People with mental illness are fully human

2) MENTAL HEALTH PROBLEMS ARE CLOSE TO HOME -not "us" versus "them"

Extremely high prevalence rates of mental disorders (NCS study) Something that the majority of us, or our families, will struggle with

3) INTEGRATION OF RESEARCH AND PRACTICE

Are beginning to develop a knowledge base re: mental illnesses & how to help people

As professionals, we have an obligation to communicate with clients about <u>what is known</u> and <u>not</u> known

While much remains to be known, research findings should serve as a guide for practice

4) THOUGHTFULNESS & LIFELONG OPEN MINDEDNESS ARE VALUABLE ASSETS

MH field is filled with unknowns, controversies, gray areas Make thoughtful & humanistic decisions

5) DIVERSITY IS EVER PRESENT & CRITICAL IN ALL ASPECTS OF THIS FIELD

Affects presentation'& description of emotions & behaviors, definitions of normality, etiology, prevalence, treatment, treatment response, etc.

ABOUT CONCEPTUAL FRAMEWORKS AND MENTAL HEALTH/ILLNESS

1) A CONCEPTUAL FRAMEWORK CAN BE A USEFUL TOOL TO HELP US AND OUR CLIENTS START THINKING ABOUT ("explaining" or making sense of) A MENTAL HEALTH PROBLEM, AS WELL AS A WAY TO BEGIN TO CONSIDER WHAT INTERVENTIONS MIGHT BE MOST USEFUL

Have been used for centuries this way in mental health
For students: A guide as to what to do after I say "hello"-how to begin to think about what's going on & what to do about it

2! CAN BE A TOOL FOR INTEGRATING RESEARCH AND PRACTICE

3) CAN BE A TOOL USEFUL~FOR EDUCATING CLIENTS & FAMILIES ABOUT MENTAL DISORDERS

4) MAKING OUR FRAMEWORK EXPLICIT IS CRITICAL BECAUSE

Frameworks ("paradigms") influence what questions we ask what research is done how we "explain" mental disorders what interventions we use

Frameworks regarding mental health are pervasive (but often hidden) in the popular media; students are often "using" a framework without realizing it, or its advantages and limitations

4) CRITERIA FOR A USEFUL FRAMEWORK FOR SOCIAL WORK MENTAL HEALTH PRACTICE-

Supported by current research
Broad & flexible enough to encompass the range of factors with which social workers deal Easy to update as we learn more Easily applied to practice

WHAT IS MEANT BY A "MENTAL DISORDER"?

Is No Agreed Upon Definition!

Ballpark: "A behavioral or psychological syndrome or pattern (of thinking, feeling, and/or

acting) which is associated with significant distress (psychological pain) and/or disability **(i.e.,** impairment in one or more important areas of functioning) ....

Grey areas/Fuzzy boundaries -e.g.,
"Mental" versus "physical" health problems
How many signs & symptoms must someone have? Which ones?
How much distress or disability? (How bad does it have to be?)
Cultural relevance -what is expected ("normal") versus "not normal"
Varies by culture, the "times", & by "who decides" (e.g. political factors)

Is a human made hypothetical construct developed for the purpose of being useful Are many pros & cons of doing such defining & labeling ~ Current way of doing things is not "cast in. stone"

MAJOR CONCEPTUAL MODELS

Biological -

Organ damage, pathology

Physical malfunction-

Energy forces

Spiritualistic-

Special relationship

Relationship with gods

Out of sync; evil **spirits**

Feelings Actions

Psychological-

Body intact; psych processes-

Psychodynamic Family & interpersonal Learning/behavioral

Cognitive

Genetic

Neurochemistry

~ "Mental Disorder"

Large social factors-

Poverty

Gender roles Oppression

Lack of social supports

~

Thoughts

LIMITATIONS OF PREVIOUS (SINGLE DOMAIN) MODELS

"SINGLE DOMAIN" ETIOLOGICAL & INTERVENTION MODELS ARE NOT SUPPORTED BY **CURRENT RESEARCH**

For virtually all mental disorders, there is no single cause. Rather, a variety of factors in the bio/psycho/social domains need to come together. Likewise, interventions from multiple domains may also be helpful.

MIND AND BODY ARE NOT SEPARATE -"MIND-BODY DUALISM" IS NOT SUPPORTED BY SCIENCE

Not only does the "mind" (brain) govern our-experiences, but there is substantial evidence that psychological & social experiences (as well as biological ones) impact/change the brain/body.

SINGLE DOMAIN MODELS LEAD TO (and are often contributed to by) COMPETITION AMONG DISCIPLINES, RATHER THAN COLLABORATION

SINGLE DOMAIN MODELS OFTEN FOCUS ON WHAT IS EASY (or politically popular) TO CHANGE, AND IGNORE OTHER AREAS REQUIRING CHANGE

REDUCTIONISM -EITHER BIOLOGICAL OR ENVIRONMENTAL -IS A DISSERVICE TO CLIENTS

It limits the questions that are asked & the research that is done
It denies the possibility of potentially useful interventions for clients

FEATURES OF AN EVIDENCE BASED, BIO/PSYCHO/$OCIAL MODEL

A MODEL OF MULTIPLE CAUSATION OR CONTRIBUTING FACTORS, ' OFTEN INTERACTING

Research suggests that, for virtually every mental disorder, a variety of factors, often interacting, in **the** biological, **psychological, and/or social domains need to come together,** to create the current picture of maladaptive thoughts, feelings, and/or actions.

A MODEL OF MULTI-DOMAIN INTERVENTION

Interventions in multiple domains (biological, psychological, and/or social) may be **necessary and/or helpful** in alleviating/diminishing the mental health problem; furthermore, interventions in different domains may sometimes have similar outcomes, thereby creating CHOICES for clients

EVIDENCE FROM RESEARCH IS USEFUL IN CONSIDERING WHAT BIOLOGICAL, PSYCHOLOGICAL, & SOCIAL FACTORS MIGHT BE CONTRIBUTING TO THE PROBLEM, AND WHAT BIOLOGICAL, PSYCHOLOGICAL, & SOCIAL INTERVENTIONS MIGHT BE HELPFUL IN ALLEVIATING/DIMINISHING THE PROBLEM

While we have MUCH to learn, science is beginning to contribute knowledge about what factors contribute to, or put a person at risk for, different kinds of mental disorders, as well as what kinds of interventions may be helpful in alleviating/diminishing them

INDIVIDUAL & CULTURAL SPIRITUAL BELIEFS SHOULD BE INCLUDED IN CONSIDERING POSSIBLE PSYCHOLOGICAL & SOCIOLOGICAL CONTRIBUTING FACTORS, AS WELL AS POTENTIALLY USEFUL PSYCHOLOGICAL & SOCIAL INTERVENTIONS

Spiritual factors/divine interventions per se cannot be studied by science

Science indicates, however, that a person's spiritual beliefs (which are often heavily influenced by an individual's culture) often play a significant role in an individual's state of physical & mental health/illness.

SUGGESTIONS FOR USE OF AN
EVIDENCE BASED, BIO/PSYCHO/SOCIAL MODEL
IN SOCIAL WORK MENTAL HEALTH PRACTICE

I. CONDUCT A COMPREHENSIVE ASSESSMENT OF THE CLIENT
What are the person's (& environment's) strengths & assets?
Where is the person (& environment) having problems?
II. CONSIDER POSSIBLE ETIOLOGICAL (CONTRIBUTING) FACTORS '
Look in all three realm: bio/psycho/social
What bio/psycho/social factors may have come together (and/or interacted)
to contribute to the current picture?
(Be sure to include consideration of personal and cultural spiritual beliefs)
What does research evidence suggest are often contributing factors to this
problem?
II1. DIAGNOSIS -- determine where (i.e., the category) the person's disorder fits in the
current classification system (DSM-IV) of mental disorders. This may be helpful in
considering possible etiological & treatment factors.
IV. CONSIDER POSSIBLE AVENUES FOR INTERVENTION
Consider possible interventions in all three realms: bio/psycho/social
(Be sure to include consideration of personal and cultural spiritual beliefs)
V. FACTORS INFLUENCING DECISION MAKING ABOUT WHAT INTERVENTION(S) TO USE
INITIALLY:
1) Which intervention(s) does research evidence suggest are often effective with
this kind of problem? What magnitude of effect is gained, and with how much time?
2) What is the cost and availability of different (hopefully effective) interventions?
(Note: Many things are often needed but not formally available-e.g., it is no
one's "role" to implement them. Consider rolling up your sleeves and doing what's
needed, and/or organizing others to do the same).
3) Which are compatible with, and draw upon the strengths and values of the .
individual client, and of the resources and values of his/her culture?
4) After giving the client (and his/her family or significant others if he/she .wishes)
information about the pros and cons of various options, what is the client's PREFERENCE
about interventions or combinations?
VI. Review and monitor steps I through V on an on-going basis. Assessment, and updating
thinking and interventions, should continue throughout your life with the client.
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Vignette

Sylvia is a 26-year-old married white female who presented with a chief complaint of "severe panic.., like I'm crawling out of my skin.., my heart feels like it's about to stop." As a consequence of these attacks, the patient had become virtually housebound. The patient states that the onset of the attacks followed the smoking of a single "joint" at a friend's party, approximately 2 years ago. The attack began that evening, and the patient had to leave the parry, accompanied by her husband of 6 months. Reportedly, he was "really pissed" at her for "being such a wimp." Over the subsequent year, the patient developed panic episodes, lasting aror, nd 20 to 40 minutes, two or three times per week. These episodes were characterized by tachycardia, dyspnea, dizziness, tingling in the fingers, and a feeling that I am going to lose my mind." The attacks often occurred without any obvious precipitant, although their frequency and intensity increased when the patient left home or when she was "thinking of something upsetting, like having a heart attack."

Sylvia regarded her marriage as "O.K." but acknowledged that "my husband definitely likes to wear the pants in the family." At the same time, the patient acknowledged her gratefulness that "he's there to help me... he helps me get out to shop and so forth... I'd 'be in real trouble without him." Her husband, Jim, revealed to the interviewer that "I kind of enjoy taking care of Sylvia, but lately, its gotten to be a pain." He recently admitted his attraction to a female co-worker and had warned Sylvia, "I don't know if I can resist much longer." Both the patient and her husband acknowledged that their sexual life had deteriorated over the past year.

The patient's past psychiatric history was essentially negative, though she acknowledged, "I've always been a little bit depressed." She also recalled a period of "school phobia" at age 5, which lasted for 2 months.

Sylvia's biological mother died when Sylvia was 2 years old, and the patient had only fragmentary recollections of a "pretty, smiling face." Sylvia acknowledged feeling "always a little hurt and-angry" that her mother had "le~" her. Her father--a businessman who was often out of town--remarried when Sylvia was 3. Sylvia recalled him as being "a real strict fundamentalist type." Her stepmother was *'kind of schizo..., like sometimes she'd hardly talk to me or hold me, and at other times it was like she folded herself right around me." The patient's biological mother, Sylvia had learned, had had a history of panic attacks **a lot like mine."

Sylvia had done well academically and had obtained a master's degree in business administration. She described herself as "real sharp at work... on top of everything. I've always been the one who solves everyone's problems at work - the troubleshoooter." In the past month, however, Sylvia had "gotten into some hassles" with her boss. Two weeks prior to evaluation, Sylvia received word that she was facing an imminent layoff because of her company's "problems with the stock market." Since that time, Sylvia's panic attacks increased to around two or three per day. Other than making the trip to and from work - accompanied by her husband, who drove her both ways--Sylvia had been virtually housebound over the past month. Sylvia described herself as "strongly religious" and "felt really bad~ that she could not get to church anymore.

A medical exam I year ago had been completely normal except for a "midsystolic click and late systolic murmur" noted by the patient's internist. An echocardiogram revealed mitral valve prolapse. The patient was given a small dose (10 mg tid) of propranolol (Inderal), which reduced some of her anxiety symptoms but left her depressed. She discontinued it and did not return to bet internist.

Drug history was negative for current alcohol abuse, cocaine, amphetamines, or other "street drugs." The patient acknowledged a "bad coffee habit," usually in excess of six cups per day.

ADVANTAGES TO SOCIAL WORKERS IN USING AN EVIDENCE BASED BIO\PSYCHO\SOCIAL MODEL

(EVERY TIME ENCOUNTER A CLIENT WHO MAY HAVE A MENTAL HEALTH PROBLEM, START THINKING ABOUT THEM IN THIS WAY)

1) Provides a useful way to begin to conceptualize what's going on with the person, and what options exist for intervention
2) Encourages a fresh and broad consideration of all domains in every case, getting away from preconceived notions of contributing factors or interventions
3) Encourages interdisciplinary collaboration rather than competition
4) Encourages problem-solving, "seeing what's needed" and doing it, rather than a narrow focus in intervening
5) Provides a useful (and empirically supported) framework for educating the client and significant others about a mental health problem

6) Enables a parallel framework for considering physical health and mental health problems

7) Is strength based as well as considering challenges in each domain
8) Encourages and enables the integration of research and practice

9) Enables hope for the future as we learn more, and allows room for easily adding new information
10) Might serve as a guide for what beginning practitioners need to learn (and what our mh concentration needs to offer)